Clear Choice Design Committee

Comments from Maine Association of Health Underwriters

August 20, 2020

State specific comments

1. California:
    a. This set of benefits appears to be the most robust but in doing so, I believe they may have locked themselves into an overly rich program with not much opportunity to use cost sharing to reduce costs. For example, in the Silver and Bronze plans, other than the HDHP options, a lot of the services were prior to the deductible which greatly diminishes the impact of the deductible. In fact, it appears that the only significant item which is applied to the deductible is inpatient hospital but with diminishing inpatient care, that deductible has little impact. Our feeling is that the negative reaction from seeing a large inpatient deductible greatly outweighs its impact on costs. You can always increase the various copays, but it would really have to be an across the board increase to have any meaningful impact. I realize consumers like services with no deductibles, only copays but that's what the higher metal levels are for and also why they are more expensive. I would strongly urge the committee to resist including a lot pre-deductible items.
    b. Also, we don't recommend making dental an integral part of the plan. Preventive dental for children is the only required benefit so making it a rider allows members with no children to avoid this cost. We understand that including it spreads a relatively small cost over a larger population making the cost in the premium even smaller but it's a benefit that many members with no dependent children will ever be able to use.'
2. Connecticut:
    a. CT has no Platinum plans available which we don't agree with. All plans participating should offer all 4 metal levels. Also, it appears that CT has separate in network and out of network deductibles and Out of Pocket (OOP)Maximums. The fact that they offer POS plans as Standard designs is a plus but not a necessity. If the objective is cost, then requiring a POS plan as a Nonstandard benefit is probably better than making it the primary plan. However, if the networks of the primary carriers aren't sufficiently complete, then a POS may be a necessity.. A plan with good network coverage should be able to offer a more competitive premium than a POS plan, even with cost controls on OON reimbursements. We've found POS plans with higher member coinsurance causes a significant amount of issues when plan members are left with high Out of Pocket costs. Balance billing above the allowed amounts causes confusion with members as well
3. DC:
    a. DC has a similar issue with services covered prior to the deductible which we've already discussed.
4. MA:
    a. The MA plans do a better job of including benefits under the deductible with most services other than physician visits going towards the deductible and then having a

copay apply. We realize that it's more cost sharing for these services, but these are services that are not really considered insurable events in the purest sense. Insurance should be for those unexpected, high cost events, not physician visits. The tradeoff is a lower premium in return for paying more out of pocket when the service is needed.

5. NYS:
    a. The State allows up to three nonstandard plans per carrier per tier but does not allow any carrier to load up their nonstandard offerings in a single tier. This prevents what amounts to an avenue around medical underwriting.
6. OR/VT:
    a. We didn't really see anything specific in these plans that would warrant additional comments beyond those we've already made

Summary notes:

Standardization of benefit plans is one of those decisions that is really not difficult to make. It should be done to achieve the goal of the ACA to allow consumers to make more informed decisions. By eliminating the need to read the minutiae of an insurance contract, enrollment will be facilitated and there will be a higher level of satisfaction with the plan chosen.

From the carrier's perspective, standardization allows plans to offer benefits they might not necessarily be inclined to for fear of adverse selection. If all plans must offer a particular therapy, for example, then any one particular plan won't be selected against if they are the only carrier to offer that benefit.

One note about benefit design of which I'm sure the Bureau is aware: any standard design needs to recognize the benchmark plan benefits and not go above since that would require the State to pick up the difference in premiums.

There needs to be a mechanism built in to regularly collect feedback from the people using the plans and also from those who choose to remain uninsured. While the collective wisdom of this Committee, the Bureau of Insurance and the Dept. of Health is broad, it certainly does not capture every sentiment from the members who will be using these plans. The feedback should be used to adjust benefits, identify gaps and possibly rating tiers. But also, it's a mechanism to provide to the members about why the plans operate the way they do. Many times, frustration can be minimized with explanations.

There have been several bills brought forward in the Legislature to offer a public option alongside private plans. While our organization has and will always oppose a public option, offering standardized plans could be a de facto public option with the Legislature determining benefits and the private carriers delivering the insurance.

To address a concern expressed on the 8/12/2020 call, the Actuarial Value (AV) calculation uses national data and is not plan specific. I think the issue was that if plan specific experience differs deductibles. e.g., will have different impacts for each plan. An inpatient deductible for a plan with a low Admission Rate per 1000 will have less of an impact on premium rates than a plan with a higher Admission Rate per 1000. We have done several Minimum Value (MV) Calculations for self-funded

Clients which is similar to the AV calculation. This also uses national data that HHS obtains from the MarketScan Commercial Claims and Encounters Database. While this is employer group data, our understanding is that the AV calculator uses similar national data which will negate any difference that may be caused by variations in plan specific experience